HEALTH PLAN FEEDBACK AND QUESTIONS TO THE PROPOSAL FOR COMBINING 2004 OIC/IPND REPORTING REQUIREMENTS

1. **Question**. *Regarding Providers Federal Tax ID number - PNPI. Is this the same as social security number? PNPI is not a data element we load into QMACS (our claims payment and provider system) unless the individual provider is the Pay To.*

   Answer. The Employers Identification Number (EIN) and Social Security Number are not the same. The IRS has a website that provides definitions of the EIN and Social Security Number. This website can be accessed by clicking on the following hypertext, EIN Definition.

2. **Question.** *Regarding Business Federal Tax ID number - BNPI. The tax ID number that we have is the Pay To Tax ID number. For the most part, this is Business Name Tax ID, but for some Capitated Groups, the IPA is the Pay To and then the Pay To tax ID number is not the BNPI, but rather the IPA tax ID.*

   Answer. Even though the above question is more of a statement, it does present an issue that requires follow-up. For confidentiality purposes, the Employer Identification Number (EIN) of the provider should be provided. We strongly encourage new providers to obtain an EIN as soon as possible rather than using their personal social security number. A federal government question and answer piece was developed to explain this rationale. It can be obtained at EIN and HIPAA Q&A.

3. **Question.** *Regarding deleting the Restricted MSO field. For our carrier, we use an IPA named "X" that has contracted specialists that can only see "X's" members unless the specialist provider has a fee for service contract with our carrier. It is nice to be able to note the IPA specialists that cannot see non IPA members by entering the IPA name in the Restricted MSO field and have that posted to the DSHS website.*

   Answer. The Restricted MSO field may be eliminated because it is not being used extensively, as a way to reduce the size of the database. However, the "X" designation could still be entered in to the "Limits Field", field # 33. This information can still be published to the website. If there are strong arguments for retaining the Restricted MSO field, please provide them, and we will take them into consideration in finalizing the new requirements.

4. **Question**. *We submit ancillary providers to the OIC as well as specialists, PCPs, hospitals and pharmacies. Under Provider Type 9 in the OIC report, we submit: PT, OT, Audiology and Speech Therapy groups, and DMEs, Home Health, Skilled Nursing, Urgent care and ASC facilities. We also submit podiatry and mental health individual providers with provider type 9. Not all specialties for Provider Type 9 are found on the Specialty Type list. Specialties that we use that are not on the Specialty Type list are Counseling (for all master's level mental*

health providers), Durable Medical Equipment, Home Health/Home Health Infusion, Skilled Nursing Facility, and Ambulatory Surgery Center. If we are to submit ancillaries on the future Report it would be helpful to have the above specialties added to the Specialty Type List.

Answer. Our agencies will add the specialties not currently on the Specialty Type list. In addition, we are in the process of defining all the provider specialties that should have a corresponding provider type.

5. **Question.** *We bring in the subcontracted Optometry providers for the OIC report. (I note they are submitted with Provider Type 1, but Optometry providers are not found on the DOH list and are not submitted to DSHS.)*

   Answer. Our agencies are working together to provide one format for submission. DSHS/MAA and HCA will consider plan feedback in determining which providers (including Optometry providers) will need to be submitted. At this point, MAA and HCA are inclined to require submission of the broader list of provider types that the OIC requires, as part of the consolidation into a single set of requirements. If these providers must be reported to the OIC anyway, this should not add substantial burden to the health plans. If health plans have concerns about this approach, MAA and HCA need to hear those concerns now in order to take them into consideration in finalizing the new data requirements.

6. ***Question****. We have been submitting 4 lines of business to the OIC (BHP+ as well as the other three). I send the OIC a file of 33,239 records and I send DSHS a file of 19,058 records. The number of records we submit will be increasing. Because of claim encounter requirements, our company has recently started loading into QMACS individual (rendering) providers for the following provider specialties. In the past, we loaded the business name only and paid claims to the business name for the following specialties:*

   Radiology
   Anesthesiology
   Urgent Care
   Emergency Medicine
   Pathology
   Hospitalists

   Answer. One of the purposes of submitting the provider file is to verify that the carrier has an adequate network. It is difficult to verify the "true" provider network if only the clinic is reported. Our agencies ask that all individual providers be submitted.

7. ***Question.*** *The validation software for the OIC report does not allow me to enter license records that begin with "TR" and "FE". The software needs to be updated to include TR and FE licenses for physicians. Also, the validation software only works if all the fields are text fields which do not correspond to the Reporting*

Requirements spreadsheet under field type. Currently, the validation software does not allow us to enter Provider ID.

Answer. This is a correct statement. Recently, the Department of Health added some additional license types. The OIC is in the process of updating its validation software.

8. ***Question.*** *We can only identify our pediatric providers through their specialty. The system does not track if a non-pediatric provider provides pediatric care. So if the default for blank records is "no", that would be a misrepresentation of our network. It would be better to just not include that field.*

   Answer. The purpose of submitting provider reports to the OIC is to verify an adequate network exists as defined by WAC 284-43-200. For example, health care providers that provide pediatric care should be tracked by the carrier to assure there is an adequate network. The carrier may not have pediatricians in a particular city but may have a large number of family practioners that also provide pediatric services. By tracking family practioners that provide pediatric services, the carrier can validate that it does have an adequate network. Therefore, it will be requested that this information be included in the carrier's data submission.

9. ***Question****. Our Information Management policy does not allow TIN information to be released externally. Please see the attached email that has a copy of the policy: (attachment omitted*)

   Answer. HIPAA stipulates that a unique employer identification number be used in the submission of claims data. Please keep in mind that a Tax Identification Number (TIN) can be a social security number or employer identification number. Our offices are specifically requesting that the EIN be submitted. Please see the attached link for more information.

10. ***Question****. Generally, we support streamlining reporting requirements and we appreciate being asked for comments well in advance of the implementation date. Our Information Systems are already set up to meet the current requirements, so to change the requirements means that we will need a significant lead time of several months minimum to change our systems.*

    Answer. Much of the information requested by our agencies is also a HIPAA requirement. Effective, October 16, 2003, HIPAA requires all plans to be compliant for electronic transfers of data. Please see the attached link for a summary of HIPAA compliance. For detailed information regarding HIPAA's role in electronic transmissions, please see the attached Federal Register link. Please note that the proposed reporting changes for the provider data base will not go into effect until January 1, 2004.

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11. ***Question****. The main challenge we see is collecting the PNPI and BNPI numbers for our entire network by a 1/1/04 deadline, especially since these numbers haven't been determined yet. Our suggestion is that IPND collect these numbers and supply them to the plans (similar to the DOH file we receive from IPND listing the providers and their Medicaid numbers). This will alleviate any burden on the providers to respond to multiple plan requests for the numbers, and will assure that plans are using the correct number for each provider.*

    Answer. IPND is evaluating this request. Potential alternatives would be to contact the federal government or secretary of state for ID numbers.

12. ***Question.*** *Another major problem is our inability to provide meaningful "capacity" numbers for each provider, since we assign to clinics instead of to individual providers. We recommend that this reporting requirement remain "optional." If there are any limitations, e.g., not accepting new patients or an age limit for patients, we can note this in a narrative field. We currently ask each provider if there any limitations and we enter the information into our system. The great majority of our providers do not have any limitations to their practice. If the "limitation" field is blank, this means that there are no limitations reported to us.*

    Answer. Our agencies have not proposed any changes to the “Capacity” field, although we are interested in continuing to work with the health plans to determine whether more useful data can eventually be provided in this field. Our agencies, however, are evaluating what currently is being reported to see if this field provides meaningful data.

13. ***Question****. The requirement to report each provider's languages is also very problematic. The feedback we received a couple of years ago is that many providers do not want to report or advertise a foreign language because they then are subject to a higher influx of this type of patient. We believe that providers will not report foreign languages to us if they perceive an adverse selection because of it. The ATT language line and interpreter services are available to meet the patients' need for foreign language interpretation and satisfy this requirement.*

    Answer. This is not a new requirement. Moreover, the Balanced Budget Act of 1997 provides that access to health care for those Medicaid eligible be available and that all policies and benefits be adequately communicated. The Civil Rights Act and the following Executive Order (see link) established the requirement that entities that receive any federal funds must comply with providing services to those with limited English proficiency. In addition, RCW 48.43.001 stipulates that “it is the intent of the legislature to ensure that all enrollees in managed care settings have access to adequate information regarding health care services covered by health carriers’ health plans, and provided by health care providers and health care facilities.” Providing interpreter services over the telephone does not satisfy the requirement. Please see the RCW link for additional information.

14. ***Question****. Adding a Pediatric Provider field. Yes, we can accommodate this change. However, it is critical that the IPND/OIC definition of "pediatrician" be clear and unambiguous. A clear definition, from our perspective, would be: all providers whose primary or secondary specialty is Family Practice, General Practice, and/or Pediatrics. It is much more problematic for us if the definition is general, e.g., all providers who report to us that they provide services to children*.

    Answer. Thank you for the suggestions. Our agencies are in the process of clarifying the provider types that should be identified as pediatric providers.

15. ***Question****. License numbers and License State: Need to sync up the validation for the license number fields. The IPND matches up against the DOH file therefore accepts some prefixes that the OIC report does not. For example, a MD with a temporary license has a license prefix of "TR". The OIC report does not recognize this license, so the prefix is changed to MD to pass the record without error. If this modification has not been changed back before the IPND report is run, then this record will then be rejected as not matching the DOH file.*

    Currently, the IPND report rejects out of state records for license formats they do not recognize. The IPND validation appears to be limited to MD, DO, ARNP, CNM, LM, MW, NP, RN, FNP, and PA that are compared against the DOH file. These are the only provider types included in the IPND report. Will this consolidation of reporting requirements incorporate a universal license validation program that meets the needs of both "Users"?

    As new license prefixes become effective, the validation program needs to incorporate the new and maintain the old formats. The old format can be phased out after a time period. The Behavioral Health providers are a recent example of a change in the prefix of the license that resulted in errors in the validation program. Providers not licensed: such as some speech and hearing providers that are certified rather than licensed. Should they be reported?

    To help ensure more accuracy it would be helpful to receive a matrix of a license prefix, license format (as we have available today) but also include applicable or acceptable professional degree(s) standard.

    Answer. Our agencies are in the process of obtaining the Idaho provider format. We are also clarifying what license types need to be accepted. The Washington State Department of Health recently added some provider type classifications. Our offices are currently updating various computer programs to accept the new provider types.

16. ***Question****. PNPI: This number is not always unique for each provider. Per record, the PNPI and BNPI will be the same*.

Answer. This situation can happen where the provider has its own practice. However, we are encouraging health carriers to collect EIN numbers from individual providers. Typically, the provider has its own EIN number and the clinic, a different EIN number. For example, this process allows the unique identification of two doctors with similar names like "Smith." Question 1 & 2 (above) also are similar to this question.

17. ***Question.*** *ProfDegree: In the IPND report we only include MD, DO, ARNP, PA, LM, MW, CNM, and FNP. Would the consolidation require inclusion of all types of providers?*

    Answer. The purpose of combining the reporting requirements is to develop one standardized set, which should streamline reporting efforts over time. Therefore, it is proposed that all provider types would need to be included for reporting purposes. If your Plan believes this will create substantially more burden rather than lead to streamlining, please explain so this information can be taken into consideration in finalizing the new reporting requirements.

18. ***Question.*** *FirstName and MiddleName: This data may be the name most recognized by a member rather than the name of the provider's license. Therefore the first name may sometimes be an Initial and the middle name is the full name.*

    Answer. The purpose of using the license number and EIN number is to uniquely identify providers. Therefore, formats for first name or middle name are not an issue.

19. ***Question.*** *DateLastCredentiald: Not all providers require credentialing. We will continue to use the OIC defined default date of 01/01/1970.*

    Answer. This is a correct statement. There are a limited number of provider types that do not currently require credentialing. Our agencies have agreed that the above default date is not an issue.

20. ***Question.*** *AcceptsNewPatients: Just for clarification, we currently report those providers with an Open practice with a "Y" indicator. If a provider is limited to accepting only their current patients, meaning if the enrollee is new to this Plan, they can continue to see their existing "limited" provider, then this provider has an "N" indicator. The "N" indicator also includes providers with a closed practice.*

    Answer. Our agencies are in the process of clarifying the definition of this field. We want to ensure that all carriers are using the same definition for reporting purposes. Additional clarifying information can also be provided in the limits field, such as "accepting established patients only."

21. ***Question****. ProviderType: Since the IPND report does not include type 4 (clinic), then locations in which all of the providers are in a not advertised status have a*

"N" indicator in the WebSite field and therefore are not included on the Website. For our company, this impacts some primary care clinics and all of the Family Planning locations. If the clinic record was included in the IPND reports, then this location could be posted on the Website, although no providers would show with it. It would at least show the inquiring member, for example, that the Family Planning clinic is woman's health care location available to them.

Answer. This is helpful feedback. Our agencies are developing the reporting requirements for data submission to all three agencies. The intent is that only a single file needs to be prepared each month that would meet the needs of all three agencies. We are in the process of clarifying the definitions of provider types.

22. ***Question****. DayPhone and AfterHoursPhone: If extensions are optional then does this change the field format to (nnn) nnn-nnnn or will you want the extension format included, but just blank?*

Answer. The current format allows numbers to be up to 23 characters, but it does not require that extensions be provided. The field format may or may not change. It may be a situation where field 47 becomes a "text" field to allow for the various formats submitted for phone extensions.

23. ***Question.*** *Due dates: If consolidated, which due date would be applied for the consolidated report, the 5th or the 10th*?

Answer. The IPND report is due the 5th of each month. The OIC is subject to a WAC that allows data submission to be provided by the 10th. Our offices are studying the impact of having carriers file the entire report not later then the 5th of each month.

24. ***Question.*** *Mailing of file: If consolidated, would GeoAccess receive a full file and pull out what they need per IPND reporting requirements? Would we have to FTP or email to multiple receivers or can this file be FTP'd to one site?*

Answer. The process is under review and will be coordinated with input from the various carriers. At a minimum, we want to enable the carriers to prepare a consistent file format that can be sent to both OIC and IPND.

25. ***Question****. Other fields removed from existing requirements:*
The following fields were not mentioned as deleted fields.
OIC – PlanID
OIC – ContractNo
OIC – Fax

Answer. This is a correct statement. The PlanID field is being renamed to CarrierID. The carrier identification number is a two digit number provided by the

OIC and will be used to cross match carrier names. The number is static for as long as the carrier reports under its name.

The ContractNo field will remain as a field, however, actual contract numbers should not be submitted and the field should be blank. Our agencies have found that the data bases submitted are very cumbersome due to the number of contracts that populate this field.

The Fax number field is being changed to "AfterHoursPhone." IPND believes that having access to an after hours telephone number is more important than capturing a fax number. In the interest of keeping the number of fields manageable, it was decided that the field should be renamed and after hours telephone numbers inserted.

26. ***Question.*** *NAIC, CIC, NCI = all assigned to carrier by OIC. Please verify what codes we should be using in these fields. We Probably have it OK already but I'd like to make sure*.

    Answer. The NAIC, CIC, NCI numbers are all assigned by or in coordination with the OIC. No change is being proposed for these fields.

27. ***Question.*** *PNPI + BNPI = Internal ID? Tax ID? I think you are looking for Tax ID here and most of our Tax ID codes are shared by the practitioner & the facility they work for. Are these numbers supposed to be unique?*

    Answer. The goal is to have a unique EIN for the provider and a different EIN number for the facility. With providers reporting slightly different names to carriers, it was determined that a unique number was required to sort out duplicates. As stated prior, HIPAA regulations allow the transmittal of EIN numbers.

28. ***Question.*** *Provider ID, Bus ID = OIC. Please tell me this is something the OIC will handle on their side and we are not going back to the old IPND format.*

    Answer. Our agencies are currently defining the provider fields. We anticipate that the Provider EIN will populate the ProviderID field. The facility EIN will populate the BusinessID field.

29. ***Question****. PR Mod Date + Bus Mod Date = what is this?*

    Answer. The PrModDate (field 25) is the last date that provider information was changed on the carrier's database. The BusModDate (field 48) is the last date that information was changed pertaining to the clinic or facility. Basically, both dates list when information was last updated or modified.

30. ***Question****. And THE most important question - Will this be full file or delta file transmission? Full file is our preference every time.*

Answer. Our agencies are requesting a full data file submission, consistent with the current OIC and IPND processes.